Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
ELITE HEALTHCARE FORT WORTH

Respondent Name
CALIFORNIA INSURANCE COMPANY

MFDR Tracking Number
M4-14-0550-01

Carrier's Austin Representative
BOX NUMBER: 06

MFDR Date Received
OCTOBER 15, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This is an approved case, more than half of the claims sent in for this patient have been paid in full. Reconsideration was done for this date of service and it was outlined key components the treating doctor provided."

Amount in Dispute: $254.09

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Please note all three key components of a new patient visit must be met in accordance to the AMA CPT coding manual to meet the evaluation and management level of service billed. According to the review of the clinic note and the documentation guidelines noted in the provisions of §134.203 (b), the documentation represents an expanded problem focused evaluation and management visit."

Response Submitted by: California Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 17, 2012	99214	$254.09	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for E/M services.

The services in dispute were reduced/denied by the respondent with the following reason codes:

- 168 – Submitted documentation does not support the level of service billed.
- 255 – Please resubmit with a more appropriate CPT/HCPCS code that better reflects services documented.
- ANSI150 – Payer deems the information submitted does not support this level of service.

- ANSI18 – Claim/service lacks information which is needed for adjudication.

Issues

1. Did the requestor meet the requirements of 28 Texas Administrative Code §134.203?
2. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §134.203(b)(1) states, in pertinent part, "for coding, billing reporting, and reimbursement of professional medical services, Texas Workers' Compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; … and other payment policies in effect on the date a service is provided…" Review of the submitted documentation finds that the requestor performed an office visit for the evaluation and management of a new patient. The American Medical Association (AMA) CPT code description for 99204 is:

   Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 45 minutes are spent face-to-face with the patient and/or family.

   The 1997 Documentation Guidelines for Evaluation & Management Services is the applicable Medicare policy. It describes the documentation requirements for the service in dispute. Review of the documentation finds the following:

   - Documentation of the Detailed History
     - History of Present Illness (HPI) consists of at least four elements of the HPI or the status of at least three chronic or inactive conditions. Documentation found listed two chronic conditions and three elements, thus, this component was not met.
     - Review of Systems (ROS) requires 10 or more systems or the pertinent positives and/or negatives of some systems with a statement "all other negative". Documentation found listed one system, thus, this component was not met.
     - Past Family, and/or Social History (PFSH) requires at least two or three history areas to be documented. The documentation found listed no areas. This component was not met.
   - Documentation of a Detailed Examination:
     - Requires general multi-system exam (8 or more systems) or a complete exam of single organ system. The documentation found listed 3 body area/organ systems: back, each extremity and muscoskeletal. This component was not met.

   The division concludes that the documentation does not sufficiently support the level of service billed.

2. For the reasons stated above, the services in dispute are not eligible for payment.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	October 20, 2014 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.